

**Investigating the moderating effects of social support and
prohibitive voice on wellbeing outcomes experienced by
support workers facing client aggression**

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Abstract

Support workers are often exposed to challenging behaviours from their clients. There is currently limited evidence of how such aggressive behaviours, including physical and verbal aggression, influence support worker' wellbeing levels, or how care organisations can mitigate the detrimental impacts of challenging behaviours on staff wellbeing. The current study explores the relationship between client-on-staff aggression and support worker wellbeing, and whether prohibitive voice and social support influence this relationship. An online survey was conducted among 225 support workers from a New Zealand care organisation. Moderated multiple regressions were conducted to test hypotheses followed. The results show that client-on-staff aggression is negatively associated with wellbeing, and that social support, but especially prohibitive voice, have positive impacts on support worker wellbeing. Furthermore, the findings also suggest, while the interactions hypothesized were not significant, the joint effects of prohibitive voice and social support uniquely explain the relationship between client-on-staff aggression and wellbeing.

Introduction

Support workers provide essential care to vulnerable populations, including the elderly, child/youth and families, and people with disabilities or mental health issues. Ongoing interaction and close contact with vulnerable individuals typically involves challenging exchanges, including instances of verbal and physical aggression (Lloyd, King, & Chenoweth, 2002; Pines & Kafry, 1978). Unfortunately, challenging client behaviours, namely aggression, are difficult to preempt or predict, particularly from clients with disabilities (Spencer & Munch, 2003). Such aggressive behaviours can have lasting effects upon employee wellbeing, both in terms of their physical health if they are physically harmed by clients, and also their mental health (Yagil, 2008). Support workers' continued exposure to these challenging episodes has been associated with their reported high levels of stress (Arnetz & Arnetz, 2001; Devereux, Hastings, & Noone, 2009) and high turnover (Kim & Stoner, 2008). Despite this, the client-centric approach that characterises social service organisations detracts from efforts to understand how the nature of the work can impact the health and wellbeing of employees (Benson & Dundis, 2003; Pines & Kafry, 1978). This has resulted in limited evidence-based knowledge of how challenging client behaviours influence support workers' wellbeing levels, and how care organisations can minimise potentially detrimental effects.

Over the past several years demand for care in communities has increased, especially with regards to mental health. For instance, an Official Information Act report from the Auckland District Health Board noted significant increases in crisis mental health referrals in the last five years, with a 300 percent increase in Auckland, 226 percent increase in the West Coast, 210 percent increase in the Bay of Plenty, and 84 percent in Canterbury ("Mental health workers struggling to cope," 2016). Previous research highlights the reality of the physical risks and emotional toll support workers and healthcare professionals face, which pose a significant threat to employee wellbeing and workplace behaviours (Devereux, Hastings, & Noone, 2009;

Kubicek & Korunka, 2015). In the healthcare sector, physical and verbal aggression upon employees has been empirically linked to negative health and wellbeing outcomes, including anxiety, burnout and depression (Grandey et al., 2012; Jayaratne & Chess, 1984; Niven, Sprigg, & Armitage, 2013). Negative wellbeing consequences of employee mistreatment in the healthcare sector have further been linked to negative outcomes that directly influence performance, including dissatisfaction with and disengagement from work, and high turnover (Kim & Stoner, 2008; Mor Barak, Nissly, & Levin, 2001). In care organisations, turnover is a significant issue as it becomes highly challenging to ensure a sense of continuity and stability among staff and clients, as well as morale (Mor Barak et al., 2001). Furthermore, high turnover among workers in care organisations is a significant concern due to its impact on quality of care, namely patient safety and access to care (Mor Barak et al., 2001).

Little can be done to prevent client-on-staff aggression from taking place in the care sector. Nevertheless, it may be possible to identify and implement practices that minimize the risk of challenging behaviours escalating to severe harm, and that mitigate the negative effects of client aggression on support workers' wellbeing. For instance, prohibitive voice, referring to employee perception that they are able to freely express their concerns about current practices, workplace incidents, or detrimental behaviours towards the organisation, is crucial in high risk work contexts (Liang, Farh, & Farh, 2012; Rusbult, Farrell, Rogers, & Mainous, 1988). Fostering prohibitive voice would therefore be useful in a care work context, and allow support workers to feel comfortable speaking up about concerns or incidents they may experience, such as aggressive behaviours from their clients. Although the literature has identified a link between prohibitive voice and wellbeing (Cox, Zagelmeyer, & Marchington, 2006; S. J. Wood & Wall, 2007), prohibitive voice is yet to be examined in regard to wellbeing in a care work setting. Furthermore, previous research indicates that prohibitive voice can buffer against the negative effects of job characteristics (Liang et al., 2012), which suggests

that prohibitive voice could minimize the negative impact of client-on-staff aggression on support worker wellbeing.

Social support has been described as the degree to which co-workers show concern for one another, engage in helping behaviours, and openly share information to enable work processes (Etzion, 1984). Social support from colleagues has been positively linked to wellbeing in the workplace (Etzion, 1984; Jenkins & Elliott, 2004; Kim & Stoner, 2008), including in healthcare organisations and professions such as nursing (Kim & Stoner, 2008). Furthermore, social support has also been identified as a buffer against the negative impact of stressful working conditions on mental and physical health among healthcare workers (Brough & Pears, 2004). This suggests that social support from co-workers may also be an important wellbeing-enhancing factor, and to help mitigate the negative impact of client-on-staff aggression on the wellbeing of support workers.

The purpose of the current study is to investigate the relationship between client-on-staff physical and verbal aggression, and employee wellbeing among support workers. It also aims to investigate the moderating effects of social support and prohibitive voice on the relationship between client-on-staff aggression and wellbeing. This will contribute to understanding the impact of client-on-staff aggression on employee wellbeing, and identify potential factors that help mitigate these negative effects.

Wellbeing in the workplace

Wellbeing refers to an individual's mental health and their psychological functioning (Ryan & Deci, 2001). Although there are variations in defining the term wellbeing, it is generally used in relation to an individual's satisfaction with their life and their experiences (Ryan & Deci, 2001; Ryff, 1989). These two ideas of life satisfaction and psychological health are reoccurring themes throughout the wellbeing literature (Danna & Griffin, 1999; Ryan & Deci, 2001). Furthermore, research has categorised two distinct views of wellbeing: hedonic

and eudaimonic. The hedonic view of wellbeing has been described by Kahneman, Diener, and Schwarz (1999) as the human search for subjective experiences of happiness or pleasure, and the avoidance of feelings of unhappiness or displeasure. The eudaimonic view of wellbeing extends the hedonic approach toward the search of happiness and involves need fulfillment. It refers to the extent to which an individual is able to psychologically function in terms of fulfilling their own values and beliefs by being true to themselves (Ryan & Deci, 2001; Waterman, 1993). This perspective captures the concept of an individual's drive to fulfill their purpose and potential, rather than just the experience of happiness (Ryff, 1995).

Although wellbeing focuses primarily on the psychological and mental health of an individual (Ryan & Deci, 2001), an individual's wellbeing can influence, and be influenced by their physical health (Danna & Griffin, 1999). When an individual experiences physical injury or illness, this can negatively impact their wellbeing through increased feelings of discomfort and pain (Ryan & Deci, 2001). An individual's physical health could also limit someone's ability to take up opportunities which could help improve their wellbeing, such as participating in physical and social activities (Ryan & Deci, 2001). An individual's psychological wellbeing can also impact physical health. Individuals who experience significant amounts of stress from various areas of their life, such as work, can experience negative physical health outcomes (Danna & Griffin, 1999).

Individuals spend a significant amount of time at work, and therefore their physical, emotional, mental, and social experiences in the workplace have a considerable influence on their wellbeing (Danna & Griffin, 1999). Organisations have increased their focus on employee wellbeing in recent years. This can be attributed to two reasons: 1) growing evidence suggesting that wellbeing is linked to positive organisational outcomes, including performance (Judge, Thoresen, Bono, & Patton, 2001; Wright & Cropanzano, 2000; Wright, Cropanzano, & Bonett, 2007), and 2) the requirements of the New Zealand Health and Safety at Work Act

2015. Regarding the first reason, organisations that invest in employee wellbeing typically exhibit higher levels of work engagement (Bakker & Schaufeli, 2008), job satisfaction (Wright & Cropanzano, 2000; Wright & Doherty, 1998), performance and productivity (Wright & Cropanzano, 2000; Wright et al., 2007), and lower turnover intentions among staff (Wright & Bonett, 2007). Conversely, low levels of wellbeing have been associated with increased errors (Boyd, 1997), increased conflicts with colleagues (De Dreu, Van Dierendonck, & Dijkstra, 2004), mental and physical health problems (Avey, Luthans, Smith, & Palmer, 2010), absenteeism (Danna & Griffin, 1999), and turnover (Wright & Bonett, 2007).

The New Zealand Health and Safety at Work Act 2015 outlines the guidelines in relation to workplace health and safety that organisations must abide by. Not only does the Act have a focus on protecting employees' physical health and safety, but it also recognizes the importance of mental health and wellbeing. The Act places significant responsibilities on organisations to have appropriate programmes, training, and policies in place to legally meet health and safety requirements and manage risks, including those associated with psychological wellbeing (e.g., harassment, bullying, fatigue, and other causes of workplace stress). Therefore, the evidence-based link between wellbeing and performance, as well as the emphasis placed on organisations' accountability for safeguarding the wellbeing of employees under the New Zealand Health and Safety at Work Act, have given rise to increasing levels of wellbeing focus and investment in a workplace context.

Client-on-staff aggression and employee wellbeing

The wellbeing of employees working in the healthcare sector is often at risk due to instances of aggressive behaviours from their clients or patients (Carter, 2000). In mental healthcare, Duxbury and Whittington (2005) reported that reasons for aggressive behaviours from patients to employees can include internal factors to the patient, such as mental illness and the behaviours associated with the illness, as well as external factors such as the

relationship between the patient and staff member, poor communication, patient response to treatment (Whittington, Shuttleworth, & Hill, 1996), and interactions with family members and other visitors (Winstanley & Whittington, 2004).

Similarly, support workers can face significant mistreatment from their clients. Previous literature has highlighted that one of the most significant challenges support workers face is aggression or abusive behaviours from their clients (Niven, Sprigg, & Armitage, 2013). Support workers face greater risk of exposure to challenging behaviours, including verbal and physical aggression, as they often provide residential care (Spencer & Munch, 2003). For instance, in 2016 the Canterbury District Health Board (CDHB) in New Zealand reported 755 cases of social work staff abused by their patients or clients in Canterbury alone (Meier, 2017).

Research suggests that instances of physical and verbal aggression from clients have a negative impact on employee wellbeing (A. Grandey, Foo, Groth, & Goodwin, 2012; Jayaratne & Chess, 1984; Niven et al., 2013). Physical aggression involves mistreatment of another through physical action, such as hitting, kicking, spitting, or sexual assault (Farrell, Bobrowski, & Bobrowski, 2006). Support workers can face this type of aggression, particularly from mental health or disability clients with limited regulatory ability (Acker, 1999). Physical aggression incidents in support work can range in severity, and be extremely detrimental to employees' mental wellbeing (Evers, Tomic, & Brouwers, 2001).

Verbal aggression occurs when an individual mistreats another through use of words, tone, and inflection, by threatening, conveying contempt, or engaging in other forms of disrespectful communication (Farrell et al., 2006). When an individual is the target of verbal abuse, such as shouting or insults, this can make them experience fear, as they may feel as though they are in danger, or experience anger, where they may feel as though they are not being treated fairly (A. A. Grandey, Kern, & Frone, 2007). Verbal aggression can be as taxing to an individual's health and wellbeing as physical aggression (A. Grandey et al., 2012).

Previous research has shown physical and verbal aggression to be associated with multiple negative outcomes for support workers including emotional exhaustion, burnout, depression, and other health outcomes (A. Grandey et al., 2012; Niven et al., 2013). Hence, the following is hypothesized:

Hypothesis 1a. Client-on-staff physical aggression is negatively associated with support worker wellbeing

Hypothesis 1b. Client-on-staff verbal aggression is negatively associated with support worker wellbeing

Voice and employee wellbeing

Instances of client-on-staff aggression among mental health practitioners and social workers are often underreported (Hutchings, Lundrigan, Mathews, Lynch, & Goosney, 2011). This presents an opportunity for organisations to develop reporting practices and systems that enable them to better assess risk in the workplace, and devise timely strategies to mitigate unsafe conditions or scenarios (Büssing & Höge, 2004). Employee voice describes an employee's perception that they are encouraged to openly voice their opinions and concerns to improve organisational functioning, or to correct inadequacies in procedures or working conditions (Hirschman, 1970; Pyman, Cooper, Teicher, & Holland, 2006; Van Dyne & LePine, 1998). Employee voice is reflected on open discussion of workplace ideas or issues with supervisors, human resources personnel, and co-workers (Botero & Van Dyne, 2009; Bowen & Blackmon, 2003). Employees are more likely to voice opinions and concerns when they feel they are in a psychologically safe environment, one in which they are able to express themselves freely without fear or repercussions (Kahn, 1990; Zhao & Olivera, 2006). Previous literature identifies two types of employee voice. Promotive voice refers to employees speaking up to give new ideas on how the organisation can be improved, and entails a future perspective in regard to improving organisational effectiveness (Liang et al., 2012; Van Dyne & LePine,

1998). The other type of employee voice of prohibitive voice, with a more limited focus throughout literature, refers to the extent to which employees feel they can express concerns about current practices, including incident reporting, detrimental behaviours towards the organisation, and potential safety risks that could be prevented (Liang et al., 2012; Rusbult et al., 1988). Prohibitive voice is important to the safety of employees working in elevated risk environments (Liang et al., 2012; Van Dyne et al., 2003).

Employee voice has been linked to a series of positive individual and organisational outcomes. In teams, employee voice has been linked to high involvement and team learning (A. Edmondson, 1999), facilitating innovation (Van Dyne, Ang, & Botero, 2003), and perceptions of safe team environment (Schwartz & Wald, 2003). Employee voice has also shown positive associations with organisational performance (S. J. Wood & Wall, 2007), goal achievement (Daley & Vasu, 2005) and staff retention (Bryson, Charlwood, & Forth, 2006). Furthermore, employee voice has been linked to job satisfaction (Holland, Pyman, Cooper, & Teicher, 2011), and to wellbeing through increased participation (Cox et al., 2006; S. J. Wood & Wall, 2007). When employees remain silent about their concerns or underreport incidents, this can lead to many negative outcomes, including the safety and wellbeing of employees. When employees do not engage in prohibitive voice, they could be putting themselves or others at risk. Underreporting incidents, or failing to share concerns about potential safety risks, result in lower levels of safety learning, and preclude preventative measures from being put in place (Liang et al., 2012). Employee voice has therefore been identified as important in healthcare settings due to the safety risks involved in this context for both employees and for patients (Morrow, Gustavson, & Jones, 2016). Furthermore, although prohibitive voice has also been previously linked to employee wellbeing (Cox et al., 2006), this type of voice has not yet been examined in a support work context. Hence, the following is hypothesized:

Hypothesis 2a. Prohibitive voice is positively and significantly related to support worker wellbeing

In addition to the proposed direct effect of prohibitive voice on wellbeing, prohibitive voice may also work as a buffer against the negative impacts of job characteristics on wellbeing (Knoll & van Dick, 2013; Liang et al., 2012; S. Wood & de Menezes, 2011). For instance, when employees engage in prohibitive voice (e.g. expressing concerns, reporting incidents, or reporting harmful behaviours), participating in such behaviour should act as a buffer against the negative effects of work conditions on wellbeing. This effect can be ascribed to an increased sense of support from the organisation, but also to the understanding that issues are taken into account and will be addressed (Liang et al., 2012; Van Dyne, Cummings, & Parks, 1995). Therefore, the current study suggests that prohibitive voice will act as a buffer to the negative impacts of aggression from clients upon employee wellbeing in a support work context.

Hypothesis 2b. Prohibitive voice will buffer against the negative impact of client-on-staff physical aggression on employee wellbeing

Hypothesis 2c. Prohibitive voice will buffer against the negative impact of client-on-staff verbal aggression on employee wellbeing

Social support and employee wellbeing

Social support has been defined by Etzion (1984) as a network of individuals who show concern for one another, enact helping behaviours, and share information through social interactions. Brough and Pears (2004) break down social support into two different areas: practical support and emotional support. Practical support refers to giving advice, and sharing resources and expertise. Emotional support consists of showing concern for, listening to, and considering others. In a workplace, there should be a combination of practical and emotional social support, an emphasis on working together as a team through collaboration, seeking and sharing advice and resources, and working through problems together (Brough & Pears, 2004).

Social support has been linked to increased levels of self-esteem, higher morale, as well as creating a sense of belonging (Heller, Swindle, & Dusenbury, 1986). Social support has also been related to increased job satisfaction (Chou & Robert, 2008; Schaefer & Moos, 1996) and staff retention (AbuAlRub, 2004).

The social support literature identifies multiple sources of support in the workplace. These include organisational social support, supervisor support, and co-worker support (Chou & Robert, 2008). A significant amount of literature either refers to social support in broad terms without specifying the source, or refer to multiple sources at once (Ducharme & Martin, 2000; Ganster, Fusilier, & Mayes, 1986; Viswesvaran, Sanchez, & Fisher, 1999). This may pose a challenge to ascertaining the wellbeing outcomes of social support, as supervisors and co-workers impact employees in different ways based on power differences, the amount of interaction time, and other factors that influence the extent and quality of the support provided (Ducharme & Martin, 2000). Furthermore, studies in the area of social support focus largely on the impact of supervisor support, and often downplay the positive influence co-workers can have as a support system (Sloan, 2012). Co-workers are essential to creating a positive team climate involving cooperation, trust, and support and are deemed as a highly important part contributing to employee wellbeing through relationships with others (Ducharme & Martin, 2000; Sloan, 2012).

In human services and healthcare occupations, social support can be particularly important as employees are working in close contact with vulnerable populations, contributing to demanding and stressful workloads, and are therefore at greater risk of negative health and wellbeing outcomes (O'Driscoll & Brough, 2003; Shinn, Rosario, Mørch, & Chestnut, 1984). The contributions of both supervisor and co-worker support to wellbeing are documented in healthcare literature, particularly in a nursing context (Constable & Russell, 1986; Jenkins & Elliott, 2004; Kim & Stoner, 2008; Leiter & Maslach, 1988). The research shows a positive

association between social support and wellbeing, and highlights the role of social support in reducing levels of burnout (Jenkins & Elliott, 2004; Van der Heijden et al., 2010). Similarly, although the relationship between co-worker support and wellbeing has not been examined in a support work context, a similar positive association is expected. Thus, the following is hypothesized:

Hypothesis 3a. Social support from co-workers is positively related to support worker wellbeing

Social support has also been identified as a buffer against the negative impacts of stressful working conditions on mental and physical health (Brough & Pears, 2004; Caplan, 1979). Although the current nursing and healthcare literature has identified the importance of social support in alleviating the negative impact of stressors on wellbeing, the research to date has not specifically examined support from co-workers, or its buffering effect on the relationship between conflict or aggression, and employee wellbeing. Turning to co-workers following mistreatment and other stressful situations has proven highly valuable in helping employees to overcome such stressful experiences (McGuire, 2007). Moreover, sharing similar experiences and insights regarding stressful situations can help maintain levels of wellbeing (Thoits, 1986). Co-workers therefore become an essential resource to maintaining wellbeing, particularly through difficult situations or experiences. This likely includes support workers' experiences of client-on-staff aggression. Thus, the following is hypothesized:

Hypothesis 3b. Social support from co-workers will buffer against the negative impact of client-on-staff physical aggression on employee wellbeing

Hypothesis 3c. Social support from co-workers will buffer against the negative impact of client-on-staff verbal aggression on employee wellbeing

Method

Participants

Participants for this study consisted of support workers from a New Zealand care organisation. This organisation provides multiple social services to communities including mental health, addiction, disability support and social housing. The care organisation agreed to invite its support workers to participate in an online survey on a voluntary basis. A total of 638 support workers from the care organisation were invited to participate in the study, 248 agreed to participate, and 225 provided completed surveys, for a response rate of 35.27%. Of these 225 participants who completed the survey, 30.7% were male ($N=69$) and 69.3% were female ($N=156$). Other demographic information was not obtained to ensure participants' sense of anonymity, and due to the sensitive nature of the information they were asked to provide.

Procedure

In this self-report, cross-sectional study, data was collected from participants via an online survey administered at a single time point. Employees were informed of and invited to participate in this study via an internal email drafted by the researcher and an organisational representative. The organisation provided their employees' email addresses so the researcher could create email panels, issue the survey link from a server outside the organisation, and target only eligible respondents. Participation was voluntary, and the care organisation allowed the employees to complete the survey during work hours. The survey was completely confidential. Participants were informed that the study had gained ethics approval from the University of Canterbury Human Ethics Committee. The survey was administered through Qualtrics linked through the invitation email where employees who chose to participate would be directed to an information and consent page (see Appendix A). If employees agreed to participate, they began the survey (see Appendix B). Participants were advised that this survey

would take around 15-20 minutes to complete. The survey was open to be completed for three weeks and employees were sent two email reminders.

Measures

The survey variables were measured using 5-point Likert rating scales through the method of self-report. The outcome variable of Wellbeing, as well as predictor variables of Physical Aggression, Verbal Aggression, Social Support, and Prohibitive Voice were all measured in the survey. The demographic variable of gender was also included.

Physical and Verbal Aggression

To measure Physical and Verbal Aggression, items were adapted from the Cohen Mansfield Agitation Inventory (CMAI) (Cohen-Mansfield, Marx, & Rosenthal, 1989) and Farrell et al. (2006) aggression scales. This included 14 items to measure Physical Aggression and 14 items to measure Verbal Aggression. These items asked participants of their experiences of clients engaging in physically and/or verbally aggressive behaviours. Participants were presented with items that relate to both types of aggression and rated how often they experienced these behaviours. A sample item for physical aggression was “hitting” and a sample item for verbal aggression was “shouting”. Participants responded on a 5-point scale was used, where 1=*never*, 2=*sometimes*, 3=*about half the time*, 4=*most of the time*, and 5=*always*. The CMAI scale has shown to have good internal consistency, ranging from .86 to .91.

Social Support – Co-worker

The four co-worker items from the Social Support scale by Caplan, Cobb, French Jr, Harrison, and Pinneau Jr (1980) were used in this study. The items assessed the extent that co-workers are viewed as helpful, reliable, and willing to listen from both a practical and an emotional sense. Participants were asked to respond to these items through selecting the response that best reflected their experience of social support from their co-workers. A sample

questions was “My colleagues go out of their way to make my work life easier”. Participants responded on a 5-point scale was used, where 1=*strongly disagree*, 2=*somewhat disagree*, 3=*neither agree nor disagree*, 4=*somewhat agree*, 5=*strongly agree*. This scale has shown good internal consistency ($\alpha = .80$).

Prohibitive Voice

A scale developed by (Liang et al., 2012) was used to measure Prohibitive Voice. The Prohibitive Voice scale included five items that measure how the employees actively engage in speaking about their concerns regarding harmful practices and incidents at work. Participants were asked to respond to these items through selecting the response that best reflected their experiences of how comfortable they feel speaking up at work. A sample questions was “I feel comfortable speaking up honestly about problems that might cause serious issues to the work unit, even when others don’t agree”. Participants responded on a 5-point scale was used, where 1=*strongly disagree*, 2=*somewhat disagree*, 3=*neither agree nor disagree*, 4=*somewhat agree*, 5=*strongly agree*. This scale shows good internal consistency, ranging from .86 to .90.

Wellbeing

The short, 7-item version of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (Tennant et al., 2007) was used as a measure of employee wellbeing. Participants were asked to think about how positively or negatively they have been feeling over the past month, and to indicate the option that best reflects their situation in regard to each item. A sample question is “I’ve been feeling good about myself”. Participants responded on a 5-point scale was used where 1=*none of the time*, 2=*rarely*, 3=*some of the time*, 4=*often*, 5=*all of the time*. This scale has been used widely and shows good internal consistency ($\alpha = .89$).

Data Analysis

The data was statistically analysed using IBM SPSS (Version 24). Before any analyses took place, participants who had not completed any of the survey questions were removed. Initial data analysis included exploratory factor analysis (EFA) to investigate the dimensionality of each scale. EFA was used to assess whether the selected measures were suitable and reliable, further evaluated through conducting reliability analysis to measure the internal consistency of each scale. Descriptive statistical analyses were also conducted to determine means and standard deviations of each variable. Bivariate correlations were also conducted to investigate the associations between variables. Following this, moderated multiple regressions were conducted to test the hypotheses.

Results

Preliminary Statistical Analysis

Exploratory Factor Analysis

Exploratory factor analyses using principal axis factoring with oblique rotation (direct oblimin) were conducted to assess the dimensionality of the measures used in the study. Detailed factor analysis information that displays rotated factor loadings, communalities, eigenvalues, and percentage of variance explained for each measure can be found in Tables A through to G in Appendix C.

The factor analysis conducted for wellbeing showed all items loaded on to a single factor explaining 52.59% of the variance. All items loaded onto this factor over the recommended cut-off of .40 (Hinkin, 1995), and therefore no items have been removed. A single factor solution was also found for co-worker support, explaining 69.59% of the variance, and for prohibitive voice, explaining 68.60% of the variance.

Examination of the initial physical aggression scale revealed 4 factors. Multiple factors were expected for this scale, as the items reflect a range of physical aggression actions such as “hitting” or “stabbing”. In this instance, the factors appeared to reflect the various levels of severity associated with forms of aggression. In considering this, all items that loaded on Factor 1 (items 2, 6, 8, and 13) were labeled as low levels of physical aggression (pushing or shoving, struck with an object, intentional falling, grabbing). The remaining items, reflecting medium to severe levels of aggression, were very rarely experienced by the support workers. In addition, most of these items (hitting, kicking, scratching, biting, hair pulling, restraint, choking, and stabbing) did not load on any factors over the cut-off of .40 and therefore were removed. In the end, the decision was to use one measure of physical aggression consisting of low levels of physical aggression (Factor 1). The low severity physical aggression factor (items

of 2, 6, 8 and 13) explained 48.36% of the variance. The scale's reliability is .77, above the recommended level of .7 (Brace, Kemp, & Snelgar, 2016).

The EFA for verbal aggression displayed two factors. The majority of items loaded in Factor 1 including items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, and 14 (insults, verbal sexual advances, rudeness, shouting, sarcasm, swearing or cursing, unjustified criticism, screaming, threat of physical abuse, client spreading rumors about you, demanding and nagging, and complaining). All of these items had factor loadings over the recommended .40 cutoff. Items 11 and 12 (threaten your property, and threaten your family) loaded on Factor 2. It was decided to remove these two items loading on Factor 2 as they refer to verbal aggression against property or family, whereas all items that loaded on Factor 1 refer to verbal aggression towards the person themselves directly rather than towards other people or property. The verbal aggression factor explains 60.13% of the variance, and the scale's reliability is .95.

Descriptive Statistics and Correlation Coefficients

Descriptive statistics, reliability coefficients, and correlations for all variables can be seen in Table 1. All internal consistency measures ranged between .77 and .95 and are above the suggested level of .7 indicating high reliability of the scales (Brace et al., 2016). The means for physical aggression ($M = 1.17$, $SD = .32$) and for verbal aggression ($M = 1.80$, $SD = .69$) suggest that most people reported 'never', 'sometimes' or 'about half the time' in regard to their experiences of aggression. The means for prohibitive voice ($M = 3.98$, $SD = .88$) and co-worker support ($M = 3.84$, $SD = .93$) suggest that the participants experience moderate levels of these variables. Furthermore, the mean obtained for wellbeing of 3.64 suggests that participants also experience moderate levels of wellbeing. The standard deviation for all variables below 1, ranging from .32 to .93, signify that participants had fairly similar experiences of co-worker support, prohibitive voice and wellbeing. The standard deviation for

co-worker support ($SD = .93$) is the closest to 1 suggesting slightly more variety in responses on experiences of co-worker support. The correlations revealed significant positive relationships between co-worker support and wellbeing ($r = .31$) and prohibitive voice and wellbeing ($r = .44$). Although wellbeing exhibited negative relationships with verbal and physical aggression, these associations were not significant.

Table 1.
Descriptive Statistics, Correlations, and Internal Consistency for all Variables

	<i>M</i>	<i>SD</i>	1	2	3	4	5	6
1. Physical Aggression	1.17	.32	(.77)					
2. Verbal Aggression	1.80	.69	.57**	(.95)				
3. Co-worker Support	3.84	.93	-.06	-.03	(.90)			
4. Prohibitive Voice	3.98	.88	-.07	-.02	.40**	(.91)		
5. Wellbeing	3.64	.68	-.11	-.13	.31**	.44**	(.88)	
6. Gender	1.69	.46	-.10	-.02	-.07	-.07	-.12	-

Note. Internal consistency (α) scores presented on the diagonal. ** $p < .01$ (two-tailed)

Independent samples t-test

Independent samples t-tests were conducted to examine if there were any significant differences in mean levels of physical aggression, verbal aggression, co-worker support, prohibitive voice, and wellbeing between males and females. The tests revealed no significant differences between males and females on any variables.

Hypothesis Testing

To test the hypotheses, moderated multiple regression analyses were conducted. The predictor variables of physical aggression, verbal aggression, co-worker support, and prohibitive voice were centered and interaction terms were created between co-worker support with physical aggression and verbal aggression, and prohibitive voice with physical aggression and verbal aggression. Variables were centered to avoid multicollinearity (Cohen, Cohen, West, & Aiken, 2013; Hofmann & Gavin, 1998). The predictor variables and interactions were entered into a regression model with wellbeing as the outcome variable.

Table 2 illustrates the result of the regression analyses. Consistent with the outcomes of the correlation analysis, Model 1, testing the relationship between wellbeing and physical and verbal aggression, was not significant. Model 2, to which co-worker support ($\beta = .15, p < .05$) and prohibitive voice ($\beta = .33, p < .01$) were added, was significant and explained 18.1% of the variance in wellbeing ($F(4, 193) 10.65, p < .001$). Model 3, in which interactions between physical aggression x co-worker support, verbal aggression x co-worker support, physical aggression x prohibitive voice, and verbal aggression x prohibitive voice were added, explained another 2.8% of variance and this increase was significant ($\Delta R^2 = .03, F(4, 189) 1.67, p < .001$). Overall, Model 3 explains 20.9% of the variance in wellbeing ($F(8, 189) 6.23, p < .001$). In Model 3, co-worker support ($\beta = .13, p < .10$), and prohibitive voice ($\beta = .33, p < .01$) were positively and significantly related to employee wellbeing, and verbal aggression (β

= -.18, $p < .05$) showed a negative and significant relationship with employee wellbeing. These findings provide support of main effects of support from co-workers and prohibitive voice on wellbeing, and the negative association between verbal aggression on wellbeing.

Table 2.

Summary of Multiple Regression Analyses for all Variables

	Wellbeing				
	<i>B</i>	<i>SE</i>	β	<i>p</i>	<i>VIF</i>
Model 1					
Physical Aggression	-.07	.05	-.04	.68	1.48
Verbal Aggression	-.11	.18	-.11	.21	1.48
R^2					.02
<i>F</i> for change in R^2					1.73
Sig <i>F</i> change					.18
Model 2					
Physical Aggression	-.01	.17	-.01	.93	1.49
Verbal Aggression	-.11	.08	-.11	.15	1.48
Co-worker Support	.11	.05	.15	.03*	1.15
Prohibitive Voice	.25	.05	.33	.00**	1.15
R^2					.18
<i>F</i> for change in R^2					19.24
Sig <i>F</i> change					.00
Model 3					
Physical Aggression	.08	.17	.04	.64	1.60
Verbal Aggression	-.18	.08	-.18	.03*	1.72
Co-worker Support	.09	.05	.13	.08^	1.21
Prohibitive Voice	.26	.05	.33	.00**	1.19
Physical Aggression x Co-worker Support	-.52	.22	-.24	.02*	2.51
Verbal Aggression x Co-worker Support	.17	.10	.19	.10	2.96
Physical Aggression x Prohibitive Voice	.15	.21	.07	.49	2.08
Verbal Aggression x Prohibitive Voice	.00	.12	.00	.99	2.43
R^2					.21
<i>F</i> for change in R^2					1.67
Sig <i>F</i> change					.16

Note. $N=225$, ^ $p < .10$; * $p < .05$; ** $p < .01$

As shown in Table 2, a significant two-way interaction was identified between physical aggression and co-worker support ($\beta = -.24$ $p < .05$). However, Figure 1 shows that this interaction was not in the direction predicted. At low levels of physical aggression, employees experienced lower levels of wellbeing when they had low co-worker support, compared to employee wellbeing at high levels of co-worker support. However, at high levels of physical aggression, low co-worker support was associated with higher levels of wellbeing than high

co-worker support. This interaction does not support the effect hypothesized (hypothesis 3b) where social support was expected to have a buffering effect against the negative impacts of client-on-staff physical aggression on wellbeing.

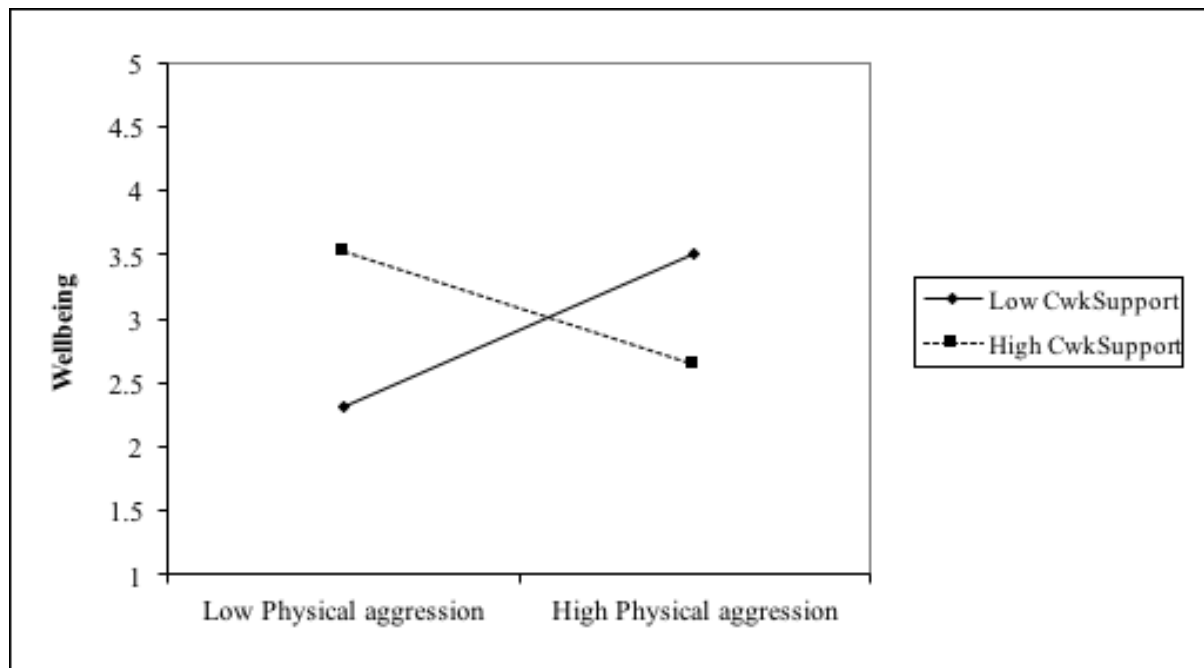


Figure 1. Two-way Interaction of Physical Aggression and Co-worker Support on Wellbeing

Table 3 outlines the hypotheses tested in this study, indicating whether they were supported.

Table 3.

Indication of Support for Hypotheses Relating to Physical Aggression, Verbal Aggression, Co-worker Support, Prohibitive Voice, and Wellbeing

	Hypothesis	Support
1a.	Client-on-staff physical aggression is negatively associated with support worker wellbeing	Not Supported
1b.	Client-on-staff verbal aggression is negatively associated with support worker wellbeing	Supported
2a.	Prohibitive voice is positively related to support worker wellbeing	Supported
2b.	Prohibitive voice will buffer against the negative impact of client-on-staff physical aggression on employee wellbeing	Not Supported
2c.	Prohibitive voice will buffer against the negative impact of client-on-staff verbal aggression on employee wellbeing	Not Supported
3a.	Social support from co-workers is positively related to support worker wellbeing	Supported
3b.	Social support from co-workers will buffer against the negative impacts of client-on-staff physical aggression on employee wellbeing	Not Supported
3c.	Social support from co-workers will buffer against the negative impacts of client-on-staff verbal aggression on employee wellbeing	Not Supported

Considering the positive albeit modest direct effect of co-worker support on wellbeing, and the strong association between prohibitive voice and wellbeing, the interaction depicted in Figure 1 could be attributed to the context in which social support occurs. For instance, it is plausible that both social support and voice are necessary to buffer against the negative effects of client-on-staff aggression on wellbeing. Having the opportunity to discuss challenging situations in a peer context, while also enjoying organisational support to report and address these issues, may represent an important combination of resources that ensure wellbeing. Post-hoc analyses (3-way interactions) were conducted to examine the interplay of social support and voice on the relationship between client-on-staff aggression and wellbeing. Slope differences tests were also conducted to identify significant slope differences (Dawson & Richter, 2006).

Post-hoc Analysis

Three-way interaction analyses for both physical aggression and verbal aggression were conducted. As shown in table 4, Model 3 shows that co-worker support and prohibitive voice were positively and significantly associated with wellbeing, whereas physical aggression was negatively and significantly associated with wellbeing. Furthermore, while none of the 2-way interactions were significant, a significant three-way interaction between physical aggression, co-worker support, and prohibitive voice was identified ($\beta = .15, p < .05$). The overall model accounted for 25% of the variance in wellbeing ($F(7, 203) 9.69, p < .001$).

Table 4.
Summary of Post-hoc Multiple Regression Analyses – Physical Aggression

	Wellbeing				
	<i>B</i>	<i>SE</i>	β	<i>p</i>	<i>VIF</i>
Model 1					
Physical Aggression	-.24	.15	-.11	.10	1.00
R^2					.01
<i>F</i> for change in R^2					2.72
Sig <i>F</i> change					.10
Model 2					
Physical Aggression	-.17	.13	-.08	.20	1.01
Co-worker Support	.12	.05	.16	.02*	1.20
Prohibitive Voice	.28	.05	.36	.00**	1.19
R^2					.01
<i>F</i> for change in R^2					26.48
Sig <i>F</i> change					.00
Model 3					
Physical Aggression	-.28	.15	-.13	.06^	1.30
Co-worker Support	.11	.05	.15	.03*	1.24
Prohibitive Voice	.28	.05	.37	.00**	1.25
Physical Aggression x Co-worker Support	-.22	.17	-.10	.19	1.52
Physical Aggression x Prohibitive Voice	.15	.17	.07	.39	1.55
Co-worker Support x Prohibitive Voice	-.07	.04	-.10	.11	1.08
Physical Aggression x Co-worker Support x Prohibitive Voice	.29	.14	.15	.04*	1.42
R^2					.25
<i>F</i> for change in R^2					2.46
Sig <i>F</i> change					.04

Note. $N=225$, ^ $p<.10$; * $p<.05$; ** $p<.01$

The three-way interaction (Figure 2) shows that different combinations of co-worker support, prohibitive voice, and physical aggression uniquely influence wellbeing levels. Wellbeing levels are maintained at moderate-to-high levels at high levels of co-worker support and high levels of prohibitive voice (1), irrespective of levels of aggression. A similar trend is found for low co-worker support and high prohibitive voice (3). Wellbeing levels were lower than these previous combinations at low levels of both prohibitive voice and co-worker support (4), irrespective of levels of aggression. Interestingly, the relationship between physical aggression and wellbeing was highly susceptible to the combination of high co-worker support and low prohibitive voice (2). At low levels of physical aggression, the combination of high

co-worker support and low prohibitive voice elicited high levels of wellbeing. However, at high levels of physical aggression the lowest levels of wellbeing were obtained with this combination of high co-worker support and low prohibitive voice. Significant slope differences were identified between this combination of moderators (2) and the other three combinations: $[(t_{1-2}(255) = 2.72, p < .05), (t_{2-3}(255) = -2.11, p < .05), (t_{2-4}(225) = -4.66, p < .01)]$. This finding suggests that when physical aggression is more frequent, and in the absence of an appropriate reporting system and culture, social support may just result in an accumulation of shared personal stories about unresolved or unheard complaints that undermine wellbeing.

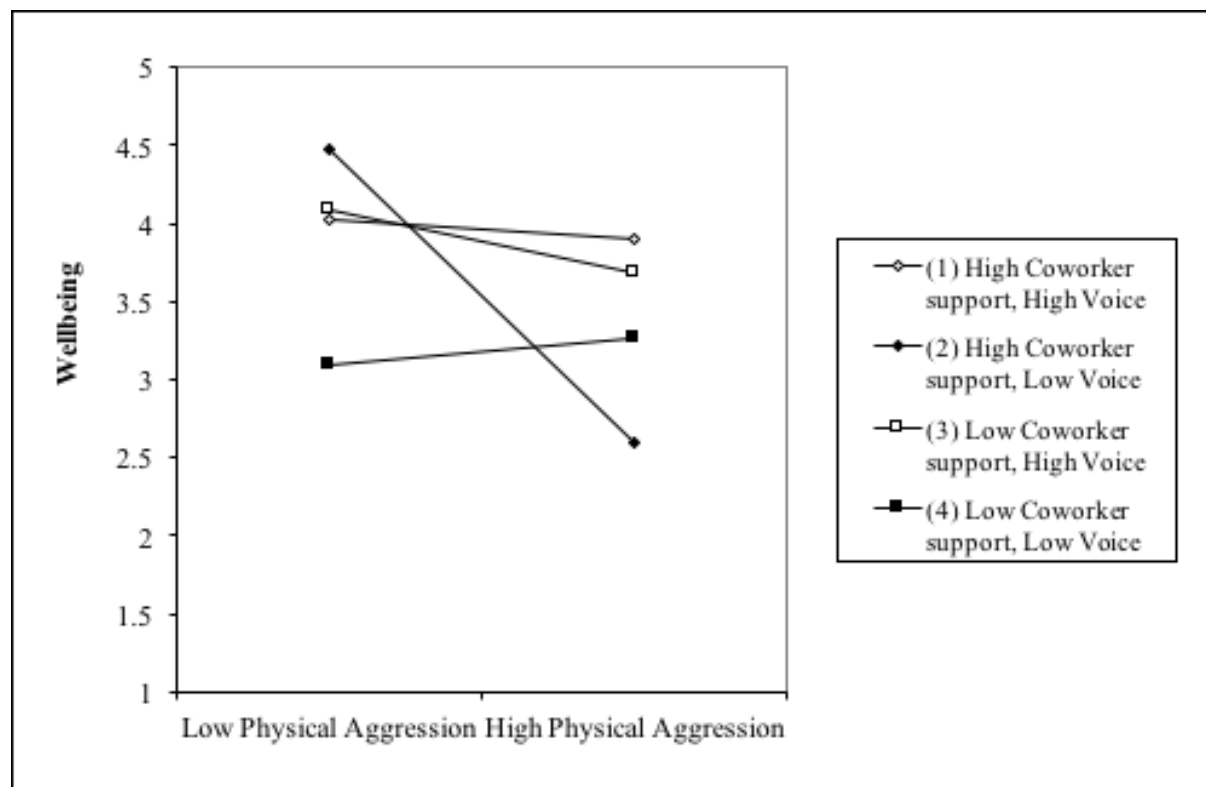


Figure 2. Three-way Interaction of Physical Aggression, Co-worker Support, and Prohibitive Voice on Wellbeing

Table 5 displays the results of the regression analyses conducted to test these 3-way interactions for verbal aggression. Aside from the main effects of verbal aggression ($\beta = -.19, p < .05$), co-worker support ($\beta = .15, p < .05$), and prohibitive voice ($\beta = .33, p < .01$) on wellbeing, there were no significant 2-way or 3-way interaction effects.

Table 5.
Summary of Post-hoc Multiple Regression Analyses – Verbal Aggression

	Wellbeing					
	<i>B</i>	<i>SE</i>	β	<i>p</i>	<i>VIF</i>	
Model 1						
Verbal Aggression	-.13	.07	-.13	.07[^]	1.00	
R^2						.02
<i>F</i> for change in R^2						3.31
Sig <i>F</i> change						.07
Model 2						
Verbal Aggression	-.12	.06	-.12	.07[^]	1.50	
Co-worker Support	.11	.05	.15	.03*	1.15	
Prohibitive Voice	.25	.05	.33	.00**	1.15	
R^2						.18
<i>F</i> for change in R^2						19.44
Sig <i>F</i> change						.00
Model 3						
Verbal Aggression	-.18	.08	-.19	.02*	1.50	
Co-worker Support	.11	.05	.15	.03*	1.23	
Prohibitive Voice	.25	.06	.33	.00**	1.19	
Verbal Aggression x Co-worker Support	.03	.08	.03	.73	1.76	
Verbal Aggression x Prohibitive Voice	.05	.10	.04	.62	1.75	
Co-worker Support x Prohibitive Voice	-.04	.05	-.06	.40	1.16	
Verbal Aggression x Co-worker Support x Prohibitive Voice	.11	.07	.13	.12	1.51	
R^2						.20
<i>F</i> for change in R^2						.88
Sig <i>F</i> change						.48

Note. *N*=225, [^] *p*<.10; **p*<.05; ***p*<.01

Discussion

Support workers deal with vulnerable populations on a daily basis, and are often exposed to challenging behaviours from their clients in the form of either physical or verbal aggression (Lloyd et al., 2002; Pines & Kafry, 1978). Not only are these behaviours difficult to preempt, but can also have a negative impact on the wellbeing of support workers (Spencer & Munch, 2003). For organisations, little can be done to prevent instances of aggression from clients upon staff, but there may be ways to minimise their negative impact on staff wellbeing. Therefore, the purpose of the current study was to verify the negative effect of client aggression on staff wellbeing, and to test whether social support and voice mitigate the negative effects of client-on-staff aggression on wellbeing.

The overall findings of the study suggest that 1) aggression from clients has a significantly negative association with support worker wellbeing, and that 2) co-worker support, but especially prohibitive voice, represent wellbeing-enhancing factors for these professionals. The first set of findings corroborate those from previous studies examining the negative impact of physical and verbal aggression on employee wellbeing (Evers et al., 2001; Grandey et al., 2007; Spencer & Munch, 2003). Further, these findings are consistent with insights from the healthcare literature, where instances of verbal abuse represent the most frequent form of aggressive behaviour seen from clients (Hahn et al., 2008).

Consistent with literature in regard to the importance of employee voice in healthcare (Morrow et al., 2016), prohibitive voice had a significantly positive relationship with support worker wellbeing. Although prohibitive voice specifically has not previously been examined in a support work context, the employee voice literature has considered prohibitive voice to be highly important in regard to the safety of employees who work in environments where they are susceptible to safety risks (Liang et al., 2012; Van Dyne et al., 2003). Prohibitive voice includes the expression of concerns about current practice, reporting incidents, reporting

detrimental behaviours toward the organisation, and reporting of potential safety risks and incidents (Liang et al., 2012; Rusbult et al., 1988). The strong main effects obtained in the present study suggest that when support workers engage in such behaviours, this has positive impacts on their wellbeing (Cox et al., 2006; Wood & Wall, 2007).

In line with findings from studies conducted in the healthcare sector, social support from co-workers was positively associated with wellbeing (Jenkins & Elliott, 2004; Van der Heijden et al., 2010). It should be noted that these effects were modest, compared to those obtained in the general healthcare literature, and were not as prominent as the association of prohibitive voice and wellbeing. Nevertheless, the results substantiate the role of social support from co-workers on the wellbeing of support workers.

The expected buffering effects of prohibitive voice and co-worker support on the relationship between client-on-staff aggression and wellbeing were not supported. This is inconsistent with literature that suggests prohibitive voice buffers against impacts of negative job characteristics on wellbeing (Knoll & van Dick, 2013; Liang et al., 2012; Wood & de Menezes, 2011). It also runs counter to research on social support, which suggests that co-worker support can be extremely valuable to help employees overcome stressful experiences (Brough & Pears, 2004; Caplan, 1979; McGuire, 2007), and may be useful in reducing the negative impact of stressful situations by having support from those that have shared similar experiences (Thoits, 1986). To further explore and elucidate these findings, 3-way interactions were conducted to examine whether and how joint levels of co-worker support and prohibitive voice influenced the relationship between client-on-staff aggression and support worker wellbeing.

The results from the analyses indicate that levels of wellbeing remain relatively high and stable, irrespective of exposure to physical aggression, at high levels of both co-worker support and prohibitive voice. The stable levels of wellbeing regardless of exposure to

aggression were also found when both co-worker support and prohibitive voice were low, though here wellbeing levels were also low. However, the combination of high co-worker support and low prohibitive voice elicited very different levels of wellbeing at low and high levels of exposure to physical aggression from clients. At low levels of physical aggression, high co-worker support was associated with high levels of wellbeing, even when perceptions of voice were low. Yet, at higher levels of client-on-staff physical aggression, high co-worker support in the absence of voice was associated with the lowest levels of wellbeing. These results highlight the wellbeing impact of feeling unable to report incidents or safety concerns, especially in environments where these incidents occur frequently (Cox et al., 2006; Liang et al., 2012). They also suggest that, in those environments, discussing client-related challenges with co-workers without receiving further support from the organisation may exacerbate the negative impact of these experiences. The contrast between the availability of informal social support and the absence of voice could highlight the frequency and severity of incidents that happen at work, cause an emotional contagion effect of the negative experiences attached to these incidents, and increase a sense of divide between employees and the organisation, as incidents are not acknowledged or resolved.

Limitations

The current study has several limitations to be addressed. Firstly, the reliance on self-report method and using a cross-sectional design. This approach can mean that the results are affected by the time period when the data was gained, and by how the respondent was feeling during this time (Kihlstrom, Eich, Sandbrand, & Tobias, 2000; Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). Furthermore, use of self-report measures brings about social desirability bias, as well as common method variance, which could have impacted the results (Podsakoff et al., 2003). Self-report surveys are susceptible to social desirability bias, as participants tend to respond in a way they believe will be viewed positively by others (Podsakoff et al., 2003;

Van de Mortel, 2008). The anonymous nature of the survey, which also stressed the importance of providing honest responses, may have mitigated the bias (Podsakoff et al., 2003). Participants also provided responses to both predictor and criterion variables at the same time, which is typically associated with common method variance (Podsakoff et al., 2003). Although there are many issues with the use of self-report, it is a highly useful tool to gain insight into individuals' perspectives, experiences, and feelings (Podsakoff et al., 2003), and was therefore deemed an appropriate approach to use for the current study. However, to limit the impacts of common method variance occurring, as previously mentioned, future research could split the predictor and criterion variables across more than one time period, or even use a full longitudinal design (Podsakoff et al., 2003). Future studies could also attempt to replicate these findings across other care organisations and countries to establish the generalizability of the results in a support work context.

Lastly, there are limitations in regard to the measures of physical and verbal aggression used in the current study. Whilst the measures used for wellbeing, co-worker support, and prohibitive voice were validated and established scales with high internal consistency, the measures used for physical and verbal aggression were adapted from two aggression scales of the Cohen Mansfield Agitation Inventory (CMAI) (Cohen-Mansfield et al., 1989), used largely in elderly care, and the aggression scale by Farrell et al. (2006), used largely in nursing. Where these scales were used in different contexts previously, a limitation of the physical and verbal aggression scales used in this study is in regard to their use in a support work context. Furthermore, the findings of the study show the prevalence of verbal aggression compared to physical aggression in a support work context. There was considerable range-restriction regarding participants' experiences of physical aggression.

Implications for Future Research and Practice

The aim of the current study was to explore the relationship between client-on-staff aggression and support worker wellbeing, and whether prohibitive voice and social support influence this relationship. Where previous literature has identified the negative impacts that both verbal and physical aggression can have on the wellbeing of individuals in healthcare (Carter, 2000; Devereux et al., 2009; A. Grandey et al., 2012; Niven et al., 2013), the current study adds to the understanding of aggression from clients in a support work setting. The current study also contributes to the support work literature through investigating the effects of both co-worker support and prohibitive voice on wellbeing in this context.

The identification of prohibitive voice and its positive impacts on support worker wellbeing contributes to the limited scope of literature surrounding prohibitive voice, separate from promotive voice, and also highlights its value in a support work context. Not only does the current study provide further support for the relationship between prohibitive voice and positive wellbeing outcomes for employees (Cox et al., 2006; Liang et al., 2012; S. J. Wood & Wall, 2007) but these findings also call for future consideration of the complex associations between prohibitive voice, safety risks, and employee behaviours and wellbeing.

The present study also extends current knowledge on social support in the workplace. Specifically, the current study further corroborates the positive impacts of support from co-workers on wellbeing (Ducharme & Martin, 2000; Sloan, 2012), particularly in a support work context. Although the effects of co-worker support were modest in comparison to the effects obtained in the broader healthcare literature, this remains a psychosocial factor to consider in relation to the wellbeing of support workers. The current study displays the positive impact of co-worker support among support workers, signifying the importance for a positive team environment in this context. Where previous literature often focuses on support from

supervisors (Sloan, 2012), the current study reinforces the importance of support from colleagues.

The current study suggests that although co-worker support is important to support worker wellbeing, it may be insufficient and even detrimental without the appropriate reporting procedures and culture. The complex relationships found between co-worker support, prohibitive voice, physical aggression, and wellbeing call for further research into the effects of a range of psychosocial factors on wellbeing outcomes, particularly among workers dealing with vulnerable populations.

Organisations in support work and healthcare need to encourage their employees to speak up on safety matters, as often these issues, including client-on-staff aggression, are too often under-reported (Hutchings et al., 2011; Spencer & Munch, 2003). The positive impacts of prohibitive voice upon support worker wellbeing suggests that organisations need to develop clear reporting practices to be able to adequately and accurately assess risks in their workplace (Büssing & Höge, 2004). Organisations need to be able to understand, track, and implement strategies to reduce unsafe conditions or scenarios (Büssing & Höge, 2004), and therefore, support workers need to be able to freely report their concerns and incidents. The information employees provide the organisation with is essential for the organisation to be able to implement appropriate actions in a timely manner to help reduce or mitigate such unsafe conditions (Büssing & Höge, 2004). Organisations therefore play a significant role in using such information not only to encourage employees to continue to report concerns and incidents, but also to mitigate or reduce safety risks (A. C. Edmondson, 2003). Employees also need to have the perception that they are able to participate in prohibitive voice and speak up in open discussion without repercussions (Kahn, 1990). Therefore, the facilitation of a psychologically safe environment is also essential for employees to feel they can freely express themselves (Kahn, 1990; Zhao & Olivera, 2006). To encourage this, organisations need to be willing to

listen and encourage mutual communication, as well as taking action to increase employee willingness to speak up (A. C. Edmondson, 2003).

Additionally, the implications of the findings from the current study suggest that organisations in support work and healthcare settings need to help promote a supportive environment between employees (Ducharme & Martin, 2000; Sloan, 2012). Support from co-workers is important to support workers, suggesting that organisations need to promote a positive team environment encouraging collaboration, sharing of advice and resources, and for employees to work through problems collectively (Brough & Pears, 2004). Organisations could initiate team building activities and opportunities for employees to get to know each other outside of work to encourage employees to build supportive relationships with each other (Medland, Howard-Ruben, & Whitaker, 2004; Robinson-Kurpius & Keim, 1994).

Overall, the results suggest that organisations need to consider multiple psychosocial factors and systems to support their employees in coping with experiences of client aggression. Although prohibitive voice and co-worker support positively influence the wellbeing of support workers separately, mitigating the negative impact of job-related risks (e.g., aggression) requires that organisations consider the joint effects of formal and informal psychosocial factors.

Conclusion

The current study has provided highly valuable information not only by extending the limited literature on support worker wellbeing, but also by providing new insights for practice regarding the wellbeing of employees who face aggression from their clients. The current study was the first to specifically examine prohibitive voice and co-worker support in a support work context and in relation to aggression. The findings of this study highlight the positive impact of prohibitive voice and co-worker support on support worker wellbeing, and clarifies how these two factors interact with exposure to client aggression to influence wellbeing.

Future studies should consider prohibitive voice and co-worker support in support work and healthcare contexts, further investigate the mitigating effects of psychosocial factors and organisational systems in regard to the wellbeing outcomes of client-on-staff aggression, and also examine types of aggression experienced by support workers. The results suggest that care organisations might benefit from developing sound reporting procedures and a strong reporting culture, as well as encouraging supportive employee relationships to help their employees cope with aggression from staff. As there is little that can be done to prevent client-on-staff aggression from occurring, further research is needed to identify and implement practices that minimize the risks, or mitigate the negative effects of client aggression on support worker wellbeing.

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Appendices

Appendix A – Information Sheet and Consent form

Psychology Department

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May 25, 2017



INFORMATION SHEET WELLBEING SURVEY

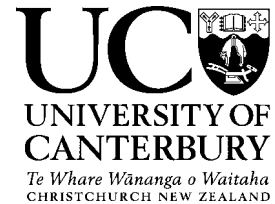
I am Shannon Smith and I am a Masters student at the University of Canterbury studying Applied Psychology. The purpose of the following research is to provide information for your organisation about how it can improve employee wellbeing among its CSWs. If you choose to take part in this study, your involvement in this project will involve the completion of a short online survey. The survey should take no more than 15 minutes.

Some of the questions in the survey may contain sensitive issues, such as the experiences of emotional/physical aggression from clients, and your current levels of wellbeing. If you do not feel comfortable answering any of the questions, you can leave them unanswered. You can withdraw from the survey at any point, and have your responses removed – just request this in one of the text questions. If you choose to leave, your employment will not be effected and your data will not be used in the research. If you have any concerns, please contact your Health and Safety Advisor. There are also other support services such as Lifeline New Zealand (0800 543 354).

The results of the project may be published, but your responses will be kept confidential. To ensure confidentiality, your responses will not be linked back to you. Only Joana Kuntz and Shannon Smith will have access to the data, which will be stored electronically on a password-protected device and destroyed after 5 years. The project will be available through the UC library. Please indicate in the survey if you would like a copy of the summary of research results.

The project is being carried out as a requirement for completion of a Masters in Applied Psychology Dissertation by Shannon Smith, under the supervision of Joana Kuntz, who can be contacted at joana.kuntz@canterbury.ac.nz. She will be happy to discuss any concerns you may have about participating. This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

Thank you for taking the time to participate in this study.



Psychology Department

Telephone: +64 3 369 4397

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Consent Form for Wellbeing Survey

- ☐ I have been given a full explanation of this project and have had the opportunity to ask questions.
 - ☐ I understand what I need to do if I agree to take part in the research.
 - ☐ I understand that participation is voluntary and I may pull out at any time without this affecting my work.
 - ☐ I understand that anything I say will be kept confidential to the researchers and that any published or reported results will not identify the participants. I understand that a thesis is a public document and will be available through the UC Library.
 - ☐ I understand that all data collected for the study will be kept on password protected computers and will be destroyed after five years.
 - ☐ I understand the risks associated with taking part and how I can get support.
 - ☐ I understand that I can contact the researcher, Shannon or supervisor, Joana, for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)
 - ☐ I would like a summary of the results of the project.
-
- ☐ By ticking this box, I agree to participate in this survey.

Email address (*for report of findings, if applicable*):

Dr Joana Kuntz (joana.kuntz@canterbury.ac.nz)

Shannon Smith (shannon.smith@pg.canterbury.ac.nz)

Appendix B – Questionnaire

Gender:

Male

Female

Or please specify _____

Employee Wellbeing (*Note: scale headings were not included in the Qualtrics participant survey*)

The following statements relate to your wellbeing. **Please think about how you have been feeling over the past month** and click the option that best reflects your situation.

Response scale: five point likert scale with anchors “None of the time”, “Rarely”, “Some of the time”, “Often”, “All of the time”.

1. I've been feeling optimistic about the future
2. I've been feeling useful
3. I've been feeling relaxed
4. I've been dealing with problems well
5. I've been thinking clearly
6. I've been feeling close to people
7. I've been able to make up my mind

Comments:

Physical Aggression

How often do you experience the following **forms of physical aggression from your clients?**

Response scale: five point likert scale with anchors “Never”, “Sometimes”, “About half the time”, “Most of the time”, “Always”

1. Hitting
2. Pushing or shoving
3. Kicking
4. Scratching
5. Spitting
6. Struck with an object (client throwing something at you)
7. Biting
8. Intentional falling
9. Hair pulling
10. Restraint (e.g. being pinned down by a client)
11. Choking

- 12. Stabbing**
- 13. Grabbing**
- 14. Physical sexual advances**

Comments:

Verbal Aggression

How often do you experience the following **forms of verbal aggression from your clients?**

Response scale: five point likert scale with anchors “Never”, “Sometimes”, “About half the time”, “Most of the time”, “Always”

- 1. Insults**
- 2. Verbal sexual advances**
- 3. Rudeness**
- 4. Shouting**
- 5. Sarcasm**
- 6. Swearing or cursing**
- 7. Unjustified criticism**
- 8. Screaming**
- 9. Threat of physical abuse**
- 10. Client spreading rumors about you**
- 11. Threaten your property**
- 12. Threaten your family**
- 13. Demanding and nagging**
- 14. Complaining**

Comments:

Social Support – Co-worker

The next statements ask about the **support you receive at work from your colleagues**. Please select the response options that best reflect your experience.

Response scale: five point likert scale with anchors “Strongly disagree”, “Somewhat disagree”, “Neither agree nor disagree”, “Somewhat agree”, “Strongly agree”

- 1. My colleagues go out of their way to make my work life easier**
- 2. My colleagues are easy to talk to**
- 3. My colleagues can be relied on when things get tough at work**
- 4. My colleagues are willing to listen to my personal problems**

Comments:

Employee Voice – Prohibitive Voice

The next statements ask about the **how comfortable you feel speaking up at work**. Please select the response options that best reflect your experience.

Response scale: five point likert scale with anchors “Strongly disagree”, “Somewhat disagree”, “Neither agree nor disagree”, “Somewhat agree”, “Strongly agree”

- 1. I feel comfortable advising my colleagues against doing things that can cause serious issues to the work unit**
- 2. I feel comfortable speaking up honestly about problems that might cause serious issues to the work unit, even when others don’t agree**
- 3. I feel comfortable giving my opinions on things that might affect the work unit**
- 4. I feel comfortable pointing out problems when they appear in the unit, even if that affects relationships with other colleagues**
- 5. I feel comfortable reporting problems in the workplace to my manager**

Comments

Appendix C – Factor Analysis Results

Table A

Factor Loadings and Communalities for Wellbeing Scale using Principal Axis Factoring and Direct Oblimin Rotation

Item	Factor 1	Communalities
I've been feeling optimistic about the future	.62	.38
I've been feeling useful	.72	.52
I've been feeling relaxed	.72	.52
I've been dealing with problems well	.75	.56
I've been thinking clearly	.75	.56
I've been feeling close to people	.76	.57
I've been able to make up my own mind	.75	.56
Eigenvalue	4.15	
% of variance (following extraction)	52.59	

Table B

Factor Loadings and Communalities for Co-worker Support Scale using Principal Axis Factoring and Direct Oblimin Rotation

Item	Factor 1	Communalities
My colleagues go out of their way to make my life easier	.77	.59
My colleagues are easy to talk to	.92	.84
My colleagues can be relied on when things get tough	.90	.80
My colleagues are willing to listen to my personal problems	.74	.55
Eigenvalue	3.07	
% of variance (following extraction)	69.59	

Table C

Factor Loadings and Communalities for Prohibitive Voice Scale using Principal Axis Factoring and Direct Oblimin Rotation

Item	Factor 1	Communalities
I feel comfortable advising my colleagues against doing things that can cause serious issues to the work unit	.78	.60
I feel comfortable speaking up honestly about problems that might cause serious issues to the work unit, even when others don't agree	.94	.88
I feel comfortable giving my opinions on things that might affect the work unit	.90	.81
I feel comfortable pointing out problems when they appear in the unit, even if that affects relationships with other colleagues	.86	.73
I feel comfortable reporting problems in the workplace to my manager	.64	.41
Eigenvalue	3.71	
% of variance (following extraction)	68.60	

Table D
Initial Factor Loadings and Communalities for Physical Aggression Scale using Principal Axis Factoring and Direct Oblimin Rotation

Item	Factor 1	Factor 2	Factor 3	Factor 4	Communalities
Hitting	.38	.23	-.37	.18	.47
Pushing or shoving	.85	.10	-.04	.11	.80
Kicking	.12	-.13	-.42	.33	.56
Scratching	.21	-.29	-.04	.32	.37
Spitting	.02	.03	-.30	.52	.49
Struck with an object (client throwing something at you)	.58	.01	-.08	.06	.42
Biting	-.02	-.20	-.88	-.11	.82
Intentional Falling	.59	-.14	.12	-.09	.33
Hair pulling	.05	-.10	-.78	.00	.70
Restraint (e.g. being pinned down by a client)	.18	-.64	.01	-.04	.48
Choking	-.06	-.92	-.14	.10	.94
Stabbing	-.08	-.77	-.12	.07	.65
Grabbing	.54	.04	-.25	.11	.53
Physical sexual advances	.01	-.05	.12	.62	.35
Eigenvalues	5.22	1.98	1.35	1.05	
% of variance (following extraction)	34.45	11.83	6.62	3.58	

Table E
Final Factor Loadings and Communalities for Physical Aggression Scale using Principal Axis Factoring and Direct Oblimin Rotation

Item	Factor 1	Communalities
Pushing or shoving	.92	.85
Struck with an object (client throwing something at you)	.61	.38
Intentional falling	.50	.25
Grabbing	.68	.46
Eigenvalue	2.38	
% of variance (following extraction)	48.36	

Table F
Initial Factor Loadings and Communalities for Verbal Aggression Scale using Principal Axis Factoring and Direct Oblimin Rotation

Item	Factor 1	Factor 2	Communalities
Insults	.82	.01	.68
Verbal sexual advances	.51	.23	.42
Rudeness	.85	.04	.76
Shouting	.90	-.06	.76
Sarcasm	.79	.06	.67
Swearing or cursing	.92	-.13	.75
Unjustified criticism	.80	.04	.67
Screaming	.73	.15	.65
Threat of physical abuse	.54	.29	.52
Client spreading rumors about you	.48	.29	.44
Threaten your property	.03	.79	.64
Threaten your family	.02	.82	.69
Demanding and nagging	.82	-.07	.63
Complaining	.78	-.16	.52
Eigenvalues	8.00	1.48	
% of variance (following extraction)	54.57	8.09	

Table G
Final Factor Loadings and Communalities for Verbal Aggression Scale using Principal Axis Factoring and Direct Oblimin Rotation

Item	Factor 1	Communalities
Insults	.83	.68
Verbal sexual advances	.62	.39
Rudeness	.87	.75
Shouting	.87	.75
Sarcasm	.82	.67
Swearing or cursing	.85	.72
Unjustified criticism	.82	.67
Screaming	.80	.64
Threat of physical abuse	.68	.47
Client spreading rumors about you	.62	.39
Demanding and nagging	.79	.62
Complaining	.69	.48
Eigenvalues	7.59	
% of variance (following extraction)	60.13	